		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0017038

Facility Name: CENTRAL PLAZA RESIDENTIAL HOME

Address: 321-27 NORTH CENTRAL (Number) CHICAGO (City) 60644 (Zip Code)

County: COOK

Telephone Number: (773) 626-2300 **Fax #** (773) 626-7647

IDPA ID Number:

Date of Initial License for Current Owners: 12/01/63

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: RICK DUROS **Telephone Number:** 847-441-8200

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 3/21/03 (Date)
(Type or Print Name) RICK DUROS
(Title) CFO

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	260	Intermediate (ICF)	260	94,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	260	TOTALS	260	94,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	90,106	239		90,345	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	90,106	239		90,345	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.20%

D. How many bed-hold days during this year were paid by Public Aid?
1,154 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/01/63

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	247,647	35,008	12,750	295,405		295,405		295,405			1
2	Food Purchase		378,740		378,740	(25,675)	353,065	(1,778)	351,287			2
3	Housekeeping	308,929		45,335	354,264		354,264		354,264			3
4	Laundry		33,606		33,606		33,606		33,606			4
5	Heat and Other Utilities			190,030	190,030		190,030	1,581	191,611			5
6	Maintenance	266,972		140,971	407,943		407,943	4,425	412,368			6
7	Other (specify):*											7
8	**TOTAL General Services**	823,548	447,354	389,086	1,659,988	(25,675)	1,634,313	4,228	1,638,541			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,269,216	24,771	13,971	1,307,958		1,307,958		1,307,958			10
10a	Therapy			424	424		424		424			10a
11	Activities	90,356	15,645	4,601	110,602		110,602		110,602			11
12	Social Services	471,288		21,750	493,038		493,038		493,038			12
13	Nurse Aide Training											13
14	Program Transportation			1,650	1,650		1,650		1,650			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,830,860	40,416	42,396	1,913,672		1,913,672		1,913,672			16
	C. General Administration											
17	Administrative	469,941		893,257	1,363,198		1,363,198	(893,257)	469,941			17
18	Directors Fees			240,000	240,000		240,000	(150,000)	90,000			18
19	Professional Services			22,536	22,536		22,536	(22,160)	376			19
20	Dues, Fees, Subscriptions & Promotions			21,924	21,924		21,924	45	21,969			20
21	Clerical & General Office Expenses	452,440		278,376	730,816		730,816	(359,332)	371,484			21
22	Employee Benefits & Payroll Taxes			579,672	579,672	25,675	605,347		605,347			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,600	1,600		1,600		1,600			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			183,597	183,597		183,597	145	183,742			26
27	Other (specify):*			19,750	19,750		19,750	(17,740)	2,010			27
28	**TOTAL General Administration**	922,381		2,240,712	3,163,093	25,675	3,188,768	(1,442,299)	1,746,469			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,576,789	487,770	2,672,194	6,736,753		6,736,753	(1,438,071)	5,298,682			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME #0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			83,165	83,165		83,165	32,923	116,088			30
31	Amortization of Pre-Op. & Org.			52,776	52,776		52,776		52,776			31
32	Interest			217,048	217,048		217,048	(77,823)	139,225			32
33	Real Estate Taxes			148,731	148,731		148,731	4,875	153,606			33
34	Rent-Facility & Grounds			30,199	30,199		30,199	(16,083)	14,116			34
35	Rent-Equipment & Vehicles			23,219	23,219		23,219		23,219			35
36	Other (specify):*											36
37	**TOTAL Ownership**			555,138	555,138		555,138	(56,108)	499,030			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,350	142,350		142,350		142,350			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			142,350	142,350		142,350		142,350			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,576,789	487,770	3,369,682	7,434,241		7,434,241	(1,494,179)	5,940,062			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	32,923	30		9
10	Interest and Other Investment Income	(67,233)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,778)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(5,773)	21		19
20	Contributions	(16,620)	19		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(199,880)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(19,750)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,201,505)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,479,616)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(14,563)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (14,563)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,494,179)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
CENTRAL PLAZA RESIDENTIAL HOME
ID# 0017038
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Allowable Directors Fees	$ (150,000)	18	1
2	Deferred Maintenance	1,808	6	2
3	Management Fees	(893,257)	17	3
4	Risk Management Fee	(6,000)	19	4
5	Miscellaneous Income	(254)	21	5
6	Trust Fee	(50)	21	6
7	Resident Christmans Gifts	(1,285)	21	7
8	Penalties	(29)	21	8
9	Non-Allowable Salaries	(152,438)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,201,505)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,778)	0	0	0	0	0	0	0	0	0	0	(1,778)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,581	0	0	0	0	0	0	0	0	1,581	5
6	Maintenance	1,808	0	2,617	0	0	0	0	0	0	0	0	4,425	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	30	0	4,198	0	0	0	0	0	0	0	0	4,228	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(893,257)	0	0	0	0	0	0	0	0	0	0	(893,257)	17
18	Directors Fees	(150,000)	0	0	0	0	0	0	0	0	0	0	(150,000)	18
19	Professional Services	(22,620)	0	0	460	0	0	0	0	0	0	0	(22,160)	19
20	Fees, Subscriptions & Promotions	0	0	8	37	0	0	0	0	0	0	0	45	20
21	Clerical & General Office Expenses	(359,709)	0	377	0	0	0	0	0	0	0	0	(359,332)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	145	0	0	0	0	0	0	0	0	145	26
27	Other (specify):*	(19,750)	0	2,010	0	0	0	0	0	0	0	0	(17,740)	27
28	**TOTAL General Administration**	(1,445,336)	0	2,540	497	0	0	0	0	0	0	0	(1,442,299)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,445,306)	0	6,738	497	0	0	0	0	0	0	0	(1,438,071)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	32,923	0	0	0	0	0	0	0	0	0	0	32,923	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(67,233)	0	0	(10,590)	0	0	0	0	0	0	0	(77,823)	32
33	Real Estate Taxes	0	0	4,875	0	0	0	0	0	0	0	0	4,875	33
34	Rent-Facility & Grounds	0	0	(16,083)	0	0	0	0	0	0	0	0	(16,083)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(34,310)	0	(11,208)	(10,590)	0	0	0	0	0	0	0	(56,108)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,479,616)	0	(4,470)	(10,093)	0	0	0	0	0	0	0	(1,494,179)	45

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Barton Management	100.00%	$ 1,581	$ 1,581	15
16	V	6	Repairs and Maint		Barton Management		2,617	2,617	16
17	V	20	Dues, Fees, Subscriptions		Barton Management		8	8	17
18	V	21	Clerical and General		Barton Management		377	377	18
19	V	26	Insurance		Barton Management		145	145	19
20	V	27	Emp. Ben. Gen Admin		Barton Management		2,010	2,010	20
21	V	33	Real Estate Taxes		Barton Management		4,875	4,875	21
22	V	34	Rental Office Space		Barton Management		17,167	17,167	22
23	V								23
24	V								24
25	V								25
26	V	34	Rent	33,250	Barton Management			(33,250)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 33,250			$ 28,780	$ * (4,470)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	Barton Healthcare LLC	100.00%	$ 460	$ 460	15
16	V	20	Dues, Subscriptions		Barton Healthcare LLC		37	37	16
17	V	32	Interest		Barton Healthcare LLC		205,034	205,034	17
18	V								18
19	V								19
20	V	32	Interest	215,624				(215,624)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 215,624			$ 205,531	$ * (10,093)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leon Sholfrock	Stockholder	Administrative	8.24	See Attached	See Attache		Betcare II	$ 0	17-3	1
2	Joe Magit	Stockholder	Admin/Director	0.07	See Attached	See Attache		Admin Sal	60,000	17-1	2
3	Joe Magit	Stockholder	Director	0.07	See Attached	See Attache		Director Fee	30,000	18-3	3
4	Irwan Jann	Stockholder	Director	13.93	N/A	1	N/A	Director Fee	30,000	18-3	4
5	Jeff Ross	Stockholder	Maintenance	0.00	N/A	40	100.00	Maint Salary	67,954	6-1	5
6	Marla Coquillette	Stockholder	Administrative	4.50	See Attached	See Attache		Admin Sal	71,667	17-1	6
7	John Sholfrock	Stockholder	Administrative	8.80	See Attached	See Attache		Admin Sal	56,667	17-1	7
8	Elisa Zusman	Stockholder	Office	8.80	See Attached	See Attache		Office Salary	10,333	21-1	8
9	Jean Shlofrock	Stockholder	Office	0.00	See Attached	See Attache		Office Salary	10,334	21-1	9
10											10
11											11
12											12
13								TOTAL	$ 336,955		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Barton Healthcare Inc
Street Address: 465 Central Ave
City / State / Zip Code: Northfield, IL
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Note Receivable	29	7	$ 2,460	$	5	$ 460	1
2	20	Dues, Subscriptions	Note Receivable	29	7	200		5	37	2
3	32	Interest	Note Receivable	29	7	1,096,002		5	205,034	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,098,662	$		$ 205,531	25

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Barton Management Inc
Street Address: 465 Central Ave
City / State / Zip Code: Northfield, IL
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Rental Income	194,550	8	$ 9,250	$	33,250	$ 1,581	1
2	6	Repairs and Maint	Rental Income	194,550	8	15,313		33,250	2,617	2
3	20	Dues, Fees, Subscriptions	Rental Income	194,550	8	48		33,250	8	3
4	21	Clerical and General	Rental Income	194,550	8	2,205		33,250	377	4
5	26	Insurance	Rental Income	194,550	8	847		33,250	145	5
6	27	Emp. Ben. Gen. Admin	Rental Income	194,550	8	11,760		33,250	2,010	6
7	33	Real Estate Taxes	Rental Income	194,550	8	28,523		33,250	4,875	7
8	34	Rent Office Space	Rental Income	194,550	8	100,446		33,250	17,167	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 168,392	$		$ 28,780	25

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Barton Healthcare LLC	x		Working Capital		1/27/95	$ 5,500,000	$ 3,299,968	demand	varible	$ 205,036	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,500,000	$ 3,299,968			$ 205,036	9
	B. Non-Facility Related*											
10	Shareholder	x		Purchase of Stock	$4,577.00	6/7/00	326,203		7/01	9.5000	1,423	10
11	Interest Income										(65,259)	11
12	Dividend Income										(1,975)	12
13												13
14	TOTAL Non-Facility Related				$4,577.00		$ 326,203	$			$ (65,811)	14
15	TOTALS (line 9+line14)						$ 5,826,203	$ 3,299,968			$ 139,225	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	145,511	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	152,822	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,311	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	146,295	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	153,606	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	154,482	8
	1998	157,224	9
	1999	156,169	10
	2000	141,273	11
	2001	146,080	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME B & D Hotel Corporation/Central Plaza Home COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0017038

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 441-8200 FAX #: (847) 441-0800

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-09-300-011-0000	324 N. Pine Ave	$ 410.00	$ 410.00
2.	16-09-300-004-0000	327 N. Central Ave	$ 39,620.00	$ 39,620.00
3.	16-09-300-005-0000	321 N. Central Ave	$ 104,917.00	$ 107,917.00
4.	Barton Management Alloc	See attached	$ 57,046.00	$ 4,875.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 201,993.00	$ 152,822.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,310 B. General Construction Type: Exterior Brick Frame _____ Number of Stories Wing#1-5Wing#2-4

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: Loan Amortization: $147,452
2. Number of Years Over Which it is Being Amortized: See attached
3. Current Period Amortization: 52,776
4. Dates Incurred: See attached

Nature of Costs: See attached
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Building	29,048	1974	$ 57,000	1
2	Building-Parking Lot		2001	199,168	2
3	TOTALS	29,048		$ 256,168	3

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	260		1974	1964	$ 385,508	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Additions			1975	303,849						9
10	Building Additions			1976	53,526						10
11											11
12	Building Additions			1977	47,780						12
13	Building Additions			1978	66,037						13
14	Building Additions			1979	59,303						14
15	Building Additions			1980	24,816						15
16											16
17	Building Additions			1980	40,762						17
18	Building Additions			1981	34,255						18
19	Building Additions			1981	10,665						19
20	Building Additions			1982	13,492						20
21	Building Additions			1983	48,201						21
22	Building Additions			1984	52,327						22
23	Building Additions			1985	295,316						23
24	Building Additions			1986	144,407						24
25	Building Additions			1987	11,075						25
26	Building Additions			1988	10,240						26
27	Building Additions			1989	39,943						27
28	Building Additions			1990	65,848						28
29	Building Additions			1991	77,448						29
30	Building Additions			1992	89,051						30
31	Building Additions			1993	46,236						31
32	Building Additions			1994	220,966						32
33	Building Additions			1994	12,302						33
34	Building Additions			1994	1,430						34
35	Building Additions			1995	125,206						35
36	Curtains			1996	1,169						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Concrete Wall	1996	$ 2,785	$		$	$	$	37
38	Boiler Repair	1996	4,763						38
39	Windows	1996	10,000						39
40	Water Heater	1996	5,100						40
41	Water Line	1996	1,985						41
42	Sidewalk Repair	1996	2,464						42
43	Storm Windows	1996	10,679						43
44	Electrical Circuit	1996	22,780						44
45	Electrical Selector	1996	2,632						45
46	House Pump	1996	22,527						46
47	Water Gate	1996	2,165						47
48	Air Conditioner Circuits	1997	6,845						48
49	Alarm Detectors	1997	634						49
50	Bathtub Refinish	1997	9,152						50
51	Bathroom Remodel	1997	5,135						51
52	Boiler Flame	1997	2,769						52
53	Ceiling Tiles	1997	623						53
54	Circuit Breakers	1997	1,920						54
55	Concrete	1997	1,300						55
56	Curtains	1997	749						56
57	Doorways	1997	6,660						57
58	Electrical	1997	1,361						58
59	Elevator	1997	42,595						59
60	Emergency Lights	1997	7,110						60
61	Fence	1997	4,500						61
62	Fire Alarm	1997	78,500						62
63	Flooring	1997	4,972						63
64	Kitchen Pipes	1997	2,200						64
65	Laundry Room	1997	24,750						65
66	Ramp Rail	1997	795						66
67	Remodeling	1997	141,653						67
68	Roof Repair	1997	14,458						68
69	Sensor Modules	1997	1,005						69
70	TOTAL (lines 4 thru 69)		$ 2,728,724	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,728,724	$		$	$	$	1
2	Water Valves	1997	1,060						2
3	Windows	1997	11,978						3
4	Bath Tub Refinish	1998	2,620						4
5	Blinds	1998	608						5
6	Electrical	1998	6,670						6
7	Elevator Remodel	1998	1,778						7
8	Emergency Lights	1998	10,323						8
9	Flooring	1998	1,600						9
10	Heat Pump	1998	1,213						10
11	Masonry/Electric	1998	11,660						11
12	Paneling	1998	1,116						12
13	Remodeling	1998	5,053						13
14	Replace Pipes	1998	2,204						14
15	Roofing	1998	3,800						15
16	Spec. Consult	1998	232						16
17	Walk in Cooler	1998	11,565						17
18	Windows	1998	18,387						18
19	Wiring	1999	4,787						19
20	Activity Area	1999	10,937						20
21	Ari Cleaners	1999	8,338						21
22	Café Line	1999	5,927						22
23	Doors	1999	4,225						23
24	Drain Line	1999	950						24
25	Electrical Panel	1999	985						25
26	Fire Damper	1999	37,670						26
27	Flooring	1999	1,304						27
28	Heater Booster	1999	2,521						28
29	Masonry/Tuckpoint	1999	11,740						29
30	Renovate Elevator	1999	9,520						30
31	Roof Repair	1999	1,050						31
32	Spec. Consult	1999	2,474						32
33	Tubs & Valves	1999	5,422						33
34	TOTAL (lines 1 thru 33)		$ 2,928,441	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,928,441	$		$	$	$	1
2	Windows	1999	30,303						2
3	Air Cleaners	2000	3,900						3
4	Bathroom Valve	2000	1,894						4
5	Carpeting	2000	749						5
6	CPU Power	2000	5,580						6
7	Door Parts	2000	1,724						7
8	Electrical Panel	2000	2,305						8
9	Elevator Switch	2000	2,300						9
10	Fire Alarm Pump	2000	1,700						10
11	Fire Code Improvement	2000	8,131						11
12	Fire Damper	2000	5,620						12
13	Fire System	2000	66,705						13
14	Hand Rails	2000	6,602						14
15	Masonry	2000	11,840						15
16	Paint & Drywall	2000	12,400						16
17	Remodel Fire Pump Room	2000	3,100						17
18	Remodel Laundry Room	2000	3,500						18
19	Remodeling	2000	15,441						19
20	Remove Walls	2000	9,600						20
21	Shower Valves	2000	4,650						21
22	Sprinkler	2000	689						22
23	Steam Line	2000	2,734						23
24	Windows	2000	24,967						24
25	Heat Detectors	2001	880						25
26	Fire Alarm	2001	1,320						26
27	Pipe Add On Devices	2001	880						27
28	Pipe Add On Devices	2001	1,320						28
29	Fire Alarm	2001	1,997						29
30	Heat Detectors	2001	1,721						30
31	Heat Detectors	2001	990						31
32	Heat Detectors	2001	660						32
33	Water Heater	2001	4,950						33
34	TOTAL (lines 1 thru 33)		$ 3,169,593	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,169,593	$		$	$	$	1
2	Wood Door	2001	570						2
3	Wood Door	2001	570						3
4	HVAC	2001	36,200						4
5	Heat Detectors	2001	2,660						5
6	Fire Alarm	2001	1,320						6
7	Panel	2001	440						7
8	Testing	2001	660						8
9	Plumbing	2001	4,050						9
10	Electrical	2001	1,180						10
11	Masonry	2001	2,450						11
12	Cubicle Curtains	2001	1,225						12
13	Reroof	2001	8,080						13
14	Elevator repair	2001	17,412						14
15	Fencing	2001	4,000						15
16	Electrical	2001	2,485						16
17	Excavating/Paving	2001	28,083						17
18	Windows	2001	18,400						18
19	Windows	2001	2,900						19
20	Boiler Parts	2001	3,148						20
21	Iron Gate	2001	1,725						21
22	Front Walk	2001	2,950						22
23	Electrical	2001	7,528						23
24	Shower room	2001	24,500						24
25	Water Heater	2001	4,950						25
26	Generator	2001	3,500						26
27	Plumbing	2001	1,340						27
28	Plumbing	2001	1,485						28
29	Plumbing	2001	1,635						29
30	Plumbing	2001	578						30
31	Smoke & Stobe Add ons	2001	16,979						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,372,596	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,372,596	$		$	$	$	1
2	Water Heater	2002	4,433						2
3	Roof Repair	2002	3,870						3
4	Remodel Weight room	2002	4,200						4
5	Remove Fire Escapes	2002	5,600						5
6	Electrical Work	2002	4,240						6
7	Plumbing Café	2002	15,294						7
8	Wiring Panels	2002	10,970						8
9	Wiring	2002	2,965						9
10	Replace Water Heater	2002	5,037						10
11	Steam Heat Repair	2002	3,370						11
12	Tuckpoint	2002	5,600						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,438,175	$		$	$	$	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 50,657	$	$	$		$	71
72	Current Year Purchases	12,338						72
73	Fully Depreciated Assets	966,263						73
74								74
75	TOTALS	$ 1,029,258	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Chevy Blazer 1997	2000	$ 21,295	$	$	$		$	76
77	Facility	Nissan Pathfinder 2001	2002	26,104						77
78	Facility	Ford Van 2003	2002	28,925						78
79										79
80	TOTALS			$ 76,324	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,799,925	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,165	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 116,088	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 32,923	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,294,211	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Barton Management - Allocation				17,167			5
6								6
7	TOTAL				$ 17,167 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Related	Facility Van	$ 584.00	$ 5,820	17
18					18
19					19
20					20
21	TOTAL		$ 584.00	$ 5,820	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,871,346	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,000)	1,942,221		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	175,840		6
7	Other Prepaid Expenses	94,055		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,083,462	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	256,168		13
14	Buildings, at Historical Cost	3,518,059		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,025,691		16
17	Accumulated Depreciation (book methods)	(3,309,545)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Rush/Barton Investment	308,145		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,798,518	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,881,980	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 127,404	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	160,735		29
30	Accrued Salaries Payable	163,041		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,133		31
32	Accrued Real Estate Taxes(Sch.IX-B)	149,295		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 635,608	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,299,968		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,299,968	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,935,576	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,946,404	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,881,980	$	48

***(See instructions.)**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,176,458	1
2	Restatements (describe):		2
3	**Unrealized Variation - Investments**	24,098	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,200,556	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,575,848	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(380,000)	9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,450,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (254,152)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,946,404	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,940,402	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,940,402	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67,233	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 67,233	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	1,689	28
28a	Phone Commissions	765	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,454	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,010,089	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,659,988	31
32	Health Care	1,913,672	32
33	General Administration	3,163,093	33
	B. Capital Expense		
34	Ownership	555,138	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	142,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,434,241	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,575,848	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,575,848	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 65,000	$ 31.25	1
2	Assistant Director of Nursing	400	427	6,972	16.33	2
3	Registered Nurses	3,920	4,080	89,542	21.95	3
4	Licensed Practical Nurses	18,159	20,126	349,620	17.37	4
5	Nurse Aides & Orderlies	69,605	75,968	701,488	9.23	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,840	11,576	90,356	7.81	10
11	Social Service Workers	31,684	33,791	455,922	13.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,754	26,194	247,647	9.45	15
16	Dishwashers					16
17	Maintenance Workers	17,904	19,263	266,973	13.86	17
18	Housekeepers	37,851	40,616	308,929	7.61	18
19	Laundry					19
20	Administrator	2,040	2,080	80,044	38.48	20
21	Assistant Administrator					21
22	Other Administrative	9,876	10,204	389,897	38.21	22
23	Office Manager					23
24	Clerical	17,254	19,576	452,440	23.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,040	2,080	47,177	22.68	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,812	2,044	24,781	12.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	249,139	270,105	$ 3,576,788 *	$ 13.24	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	313	$ 12,750		35
36	Medical Director	132	4,200		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	11	424		41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	112	4,601		44
45	Social Service Consultant	312	10,530		45
46	Other(specify)				46
47	Psychiatric Consultant	307	10,720		47
48	Psychiatric Director	8	500		48
49	TOTAL (lines 35 - 48)	1,291	$ 45,525		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	605	7,972		52
53	TOTAL (lines 50 - 52)	605	$ 7,972		53

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gwen Washington	Administrator	0	$ 80,044
Marla Coquillette	Administrative	4.5	71,667
Arnie Kanter	Administrative	0	51,873
Joe Magit	Administrative	6.8	60,000
John Shlofrock	Administrative	8.8	97,756
Rick Duros	Administrative	0	62,453
Gary Weintraub	Administrative	0	46,148
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 469,941

B. Administrative - Other

Description	Amount
Management Fees (Adjusted out on page 5)	$ 893,257
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 893,257

C. Professional Services

Vendor/Payee	Type	Amount
Lawrencewood Financial	Accounting	$ 6,000
Pension Performance	Accounting	2,772
Alpha Data Services	Data Processing	4,328
Accumed	Computer Service	925
Barton Mgmt Allocation	Computer Service	6,057
Personnal Planner	Unemploymt Consult	1,890
Misc	Other Professional Serv	64
Omnicare	Computer Service	500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 22,536

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,466
Unemployment Compensation Insurance	29,581
FICA Taxes	248,697
Employee Health Insurance	215,294
Employee Meals	25,672
Illinois Municipal Retirement Fund (IMRF)*	
Employee Head Tax	5,540
Employee Benefits-other	6,094
TOTAL (agree to Schedule V, line 22, col.8)	$ 605,344

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,922
Health Care Worker Background Check	526
(Indicate # of checks performed 75.1)	
City of Chicago Licenses	1,000
Franchise Tax	50
Misc Dues & Subs & Licenses	373
Barton Mangmt Alloction	295
Dues - IL Council LTC	13,783
Less: Public Relations Expense	( )
Non-allowable advertising	20
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,969

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,600
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,600

**See instructions.

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME # 0017038 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Decorating	12/99	$ 2,645	3	$ 882	$ 882	$ 882	$	$	$	$	$	$
2	Decorating	12/00	4,257	3		1,419	1,419	1,419					
3	Decorating	12/01	3,819	3			1,273	1,273	1,273				
4	Decorating	12/02	2,652	3				884	884	884			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 13,373		$ 882	$ 2,301	$ 3,574	$ 3,576	$ 2,157	$ 884	$	$	$

Facility Name & ID Number CENTRAL PLAZA RESIDENTIAL HOME **#** 0017038 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Only CNA's**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **n/a** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **142,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,675** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **no**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **n/a**
Attach invoices and a summary of services for all architect and appraisal fees.